WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

File Naming Example:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

COMMITTEE NOTICES ...

- *Committee Hearings ... CH* (Public Hearing Announcements)
- **

- *Committee Reports ... CR*
- **

- *Executive Sessions ... ES*
- **

- *Record of Comm. Proceedings ... RCP*
- **

INFORMATION COLLECTED BY COMMITTEE CLERK FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- **

Name:

- *Clearinghouse Rules ... CRule*
- **

- *Hearing Records ... HR* (bills and resolutions)
- **05hr_ab0766_AC-In_pt04**

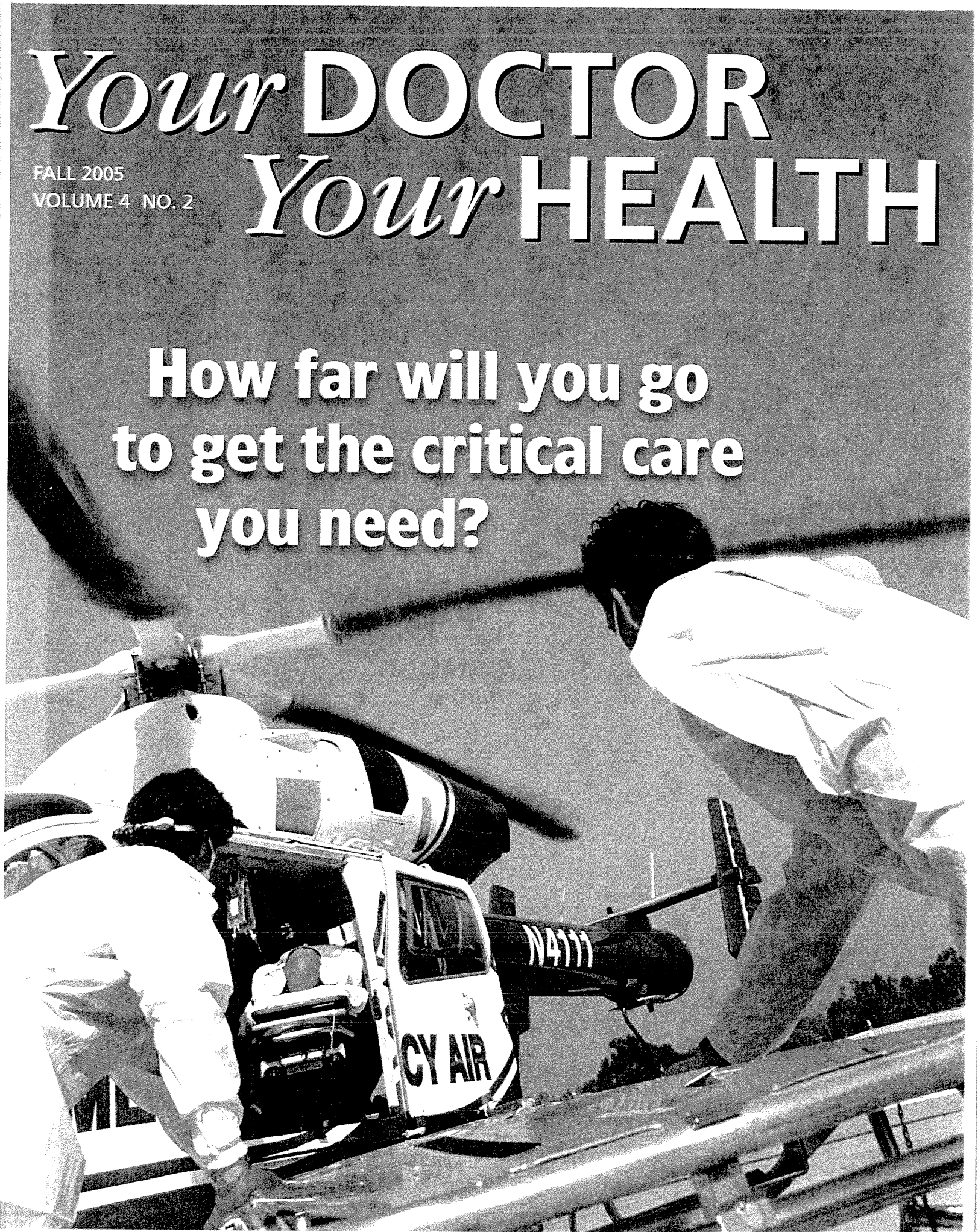
- *Miscellaneous ... Misc*
- **

PROVIDED BY YOUR PHYSICIAN, A MEMBER OF THE WISCONSIN MEDICAL SOCIETY

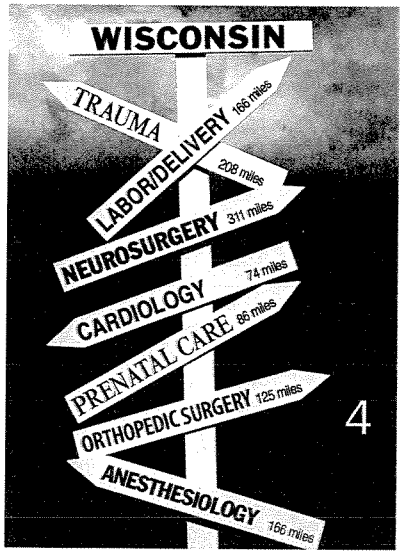
Your DOCTOR *Your* HEALTH

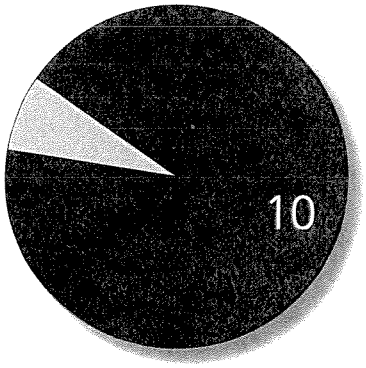
FALL 2005
VOLUME 4 NO. 2

How far will you go to get the critical care you need?



Your DOCTOR *Your* HEALTH





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Your Doctor. Your Health.

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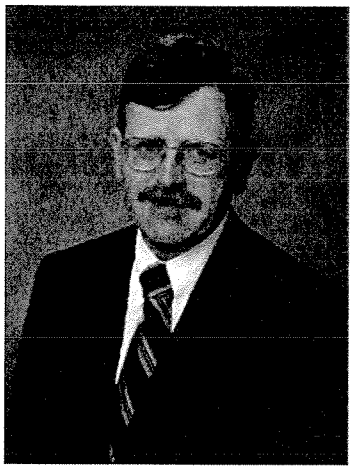
Fixing what the Supreme Court broke



Mark K. Belknap, MD, specializes in internal medicine in Ashland, Wis.

It was barely two years ago when a Congressional aide from Illinois called the Wisconsin Medical Society to ask, "What are you people doing over there? One by one, our doctors are leaving here and going to Wisconsin."

The truth is we weren't doing anything at that moment. It was bipartisan efforts begun 30 years ago that helped Wisconsin become a magnet for doctors from other states, including Illinois. They were coming to our state because they either couldn't afford to pay enormous insurance premiums or they were unable to find an insurance company to cover them in Illinois at any price. In fact, the last two brain surgeons in Southern Illinois left last year, requiring severely injured patients to be airlifted to Missouri. Luckily, they were recently able to recruit one replacement.

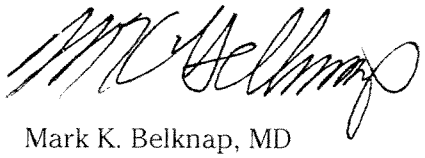
Wisconsin hasn't had these problems because our state had been progressive. We addressed the factors that drive sky-high premiums, while also assuring that patients injured through medical negligence receive all of the compensation necessary to cover hospital bills, lost wages and other tangible economic losses.

But on July 14, the Wisconsin Supreme Court announced a ruling that turned everything upside down. In a 4-3 decision, the Court threw out the cap on noneconomic damages in medical liability cases. These are the awards for pain and suffering, loss of companionship and other emotional scars that are impossible to quantify.

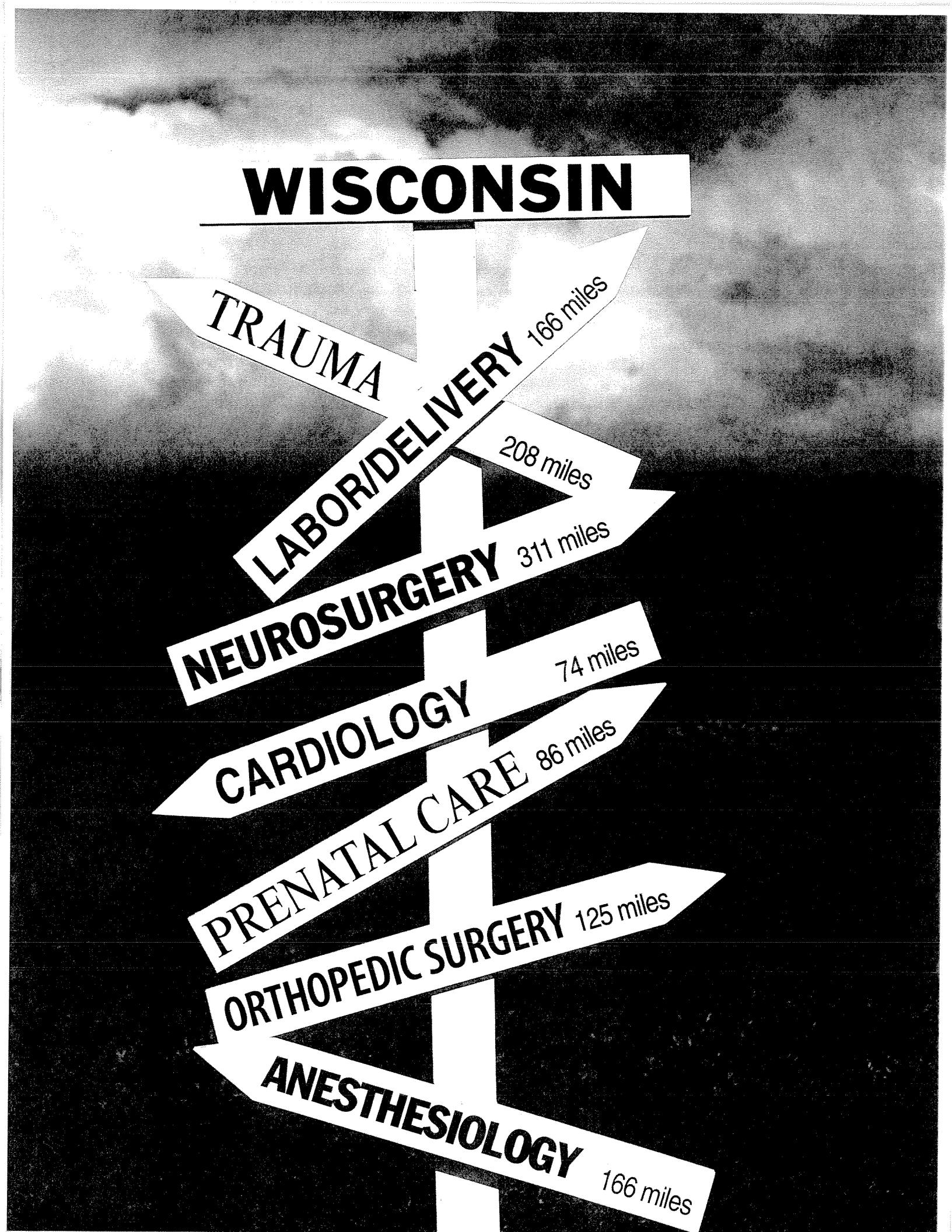
This means Wisconsin now has no limits whatsoever on awards in non-governmental medical liability cases, which may mean higher health costs, more lawsuits, larger judgments and rising insurance premiums to cover the heightened risk. The most important result, though, is that it may become more challenging to find doctors who perform high-risk procedures. This is a big concern for smaller communities and inner cities, where we already have a physician shortage. It also may mean early retirements or doctors leaving for other states.

This means Wisconsin now has no limits whatsoever on awards in non-governmental medical liability cases, which may mean higher health costs, more lawsuits, larger judgments and rising insurance premiums to cover the heightened risk.

But we don't have to let this happen in Wisconsin. Read this issue of *Your Doctor. Your Health.*, then log on to keepdoctorsinwisconsin.org and get involved. The most important thing you can do is let your legislators know that you support efforts to pass a new limit on noneconomic damages that will survive constitutional muster.



Mark K. Belknap, MD
President, Wisconsin Medical Society


WISCONSIN
TRAUMA
LABOR/DELIVERY 166 miles
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CARDIOLOGY 74 miles
PRENATAL CARE 86 miles
ORTHOPEDIC SURGERY 125 miles
ANESTHESIOLOGY 166 miles

Distance no one can afford to travel

By Steve Busalacchi

Wisconsin Supreme Court ruling could lead to higher insurance premiums and jeopardize critical access to health care

By definition, birth is a time of new beginnings. But not always. Not for Katherine Merrill, MD, of Astoria, Oregon. For this Medical College of Wisconsin graduate, one particular birth in August of 2003 signaled the end of something very special for her personally and professionally.

"It was really hard," recalls Dr. Merrill. "I went into family practice because I wanted to do everything–the old cradle to grave concept. I felt pretty strongly about it, so I went to a residency program that was quite strong in obstetrics."

But circumstances beyond Merrill's control forced her to quit delivering babies. "The last patient that I delivered before I gave up obstetrics was the first person that I ever delivered in town. I delivered three of her four children in that time," explained Dr. Merrill.

So why leave obstetrics? In 1999, the Oregon Supreme Court ruled that the state's cap on noneconomic damage awards in medical negligence cases was unconstitutional. And soon afterward, liability insurance rates took off like a rocket. Insurance premiums for family practice physicians who deliver babies soared 332 percent, while general surgeons have seen increases of 196 percent, according to a 2004 analysis by the economic consulting firm ECONorthwest. The firm reported premium increases of 221 percent for obstetricians.

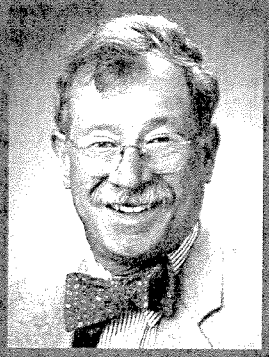
After six months in private practice with another family medicine colleague, Dr. Merrill's premium doubled, despite the fact that neither doctor had been sued. When the insurance renewal notice came the next year, their premium doubled yet again. That was the last straw, which made the call both an easy and a sad one.

"I made the decision so I could remain financially viable and stay in town," says Dr. Merrill. "There's nobody in our entire county delivering babies from an FP (family practice) perspective." She and her partner were the last two family doctors offering obstetrics care.

Doctor shortage in Wisconsin?

Could something like this happen in Wisconsin? On July 14, the State Supreme Court announced a ruling throwing out Wisconsin's

Survivors of the medical liability crisis who 'escaped to Wisconsin'



Peter Areson, MD, General Surgeon
Left Maine; now practicing in Ashland, Wis.

After Dr. Areson's insurer in Maine stopped writing liability insurance, his premiums with a new company went from $50,000 to $125,000, with inferior coverage. "I looked specifically for 'safe' states, from a malpractice standpoint," explains Dr. Areson. When a colleague and friend from Appleton told him about the stability in Wisconsin, he looked into it and eventually moved to Ashland, where he is quite happy, though concerned about the Supreme Court's decision to lift the cap on noneconomic damages.

Shawn Hennigan, MD, Orthopedic Surgeon
Left Pennsylvania; now practicing in Green Bay, Wis.

Doctor Hennigan left his home state of Pennsylvania in July of 2003. When he moved to Green Bay, his premium dropped from $100,000 to $20,000 per year. Doctor Hennigan considered Wisconsin because, at the time, it was one of six states in the nation with a stable liability market.

cap on noneconomic damages, which include compensation for pain and suffering and loss of companionship. This means that Wisconsin now has no limits whatsoever for awards in liability cases involving private medical practices and hospitals.

If Nevada, Pennsylvania, Ohio, Oregon and many other states are a guide, there eventually may be shortages of doctors who perform high-risk procedures here. When there's a potential for an enormous jury award, of which trial attorneys may receive one-third or more, lawyers may be more willing to take a chance on a case involving a sad outcome, whether actual negligence was involved or not. "Defending these extra suits will surely tax our health care system because they will lead to higher medical liability premiums," said **Susan Turney, MD**, who is Executive Vice President/CEO of the Wisconsin Medical Society.

"Nobody knows what type of similar situations will occur in Wisconsin if the system is allowed to spiral down out of control in the absence of caps and necessary physician protections," said Brad Cole, Mayor of Carbondale, Ill., speaking at a Madison news conference August 25. This is a topic Cole happens to know quite a bit about. His southern Illinois community lost the region's only two neurosurgeons in May of 2004, forcing critically injured patients to be taken by helicopter to Missouri for care.

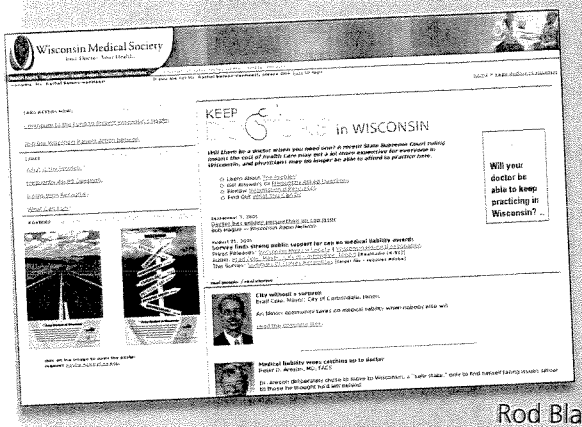
"I never want to deliver the eulogy again at a funeral that could've been prevented by sound and proper legislation to keep doctors practicing and protecting patients and saving lives," said Mayor Cole, referring to the loss of a friend who died after having to wait four hours to see a neurosurgeon. *(See Cole's guest column on page 10.)*

Reason for optimism

But Dr. Turney sees reason to be optimistic. "A clear majority of likely voters, when given the facts, understand that unlimited damage awards will eventually raise their medical costs," she says. "And of course, that will mean disruptions in their medical care, too." So she's hopeful that there will be enough public support to convince the Legislature and Governor to re-establish a cap on noneconomic damages that is constitutional.

www.keepdoctorsinwisconsin.org

Learning from Illinois



By Steve Busalacchi

The Wisconsin Medical Society has created www.keepdoctorsinwisconsin.org to educate and empower the public so citizens can support public policy that prevents medical liability problems from handcuffing our health care system.

To accomplish this goal, informed patients will need to join with the medical community and let lawmakers and the Governor know how they feel, just as citizens did in Illinois. Following a public outcry for reform, Illinois Governor Rod Blagojevich signed legislation in August establishing a cap on noneconomic damage awards and other reforms. The leaders of Carbondale, a small community in southern Illinois, were so concerned that they passed an ordinance that created a local limit on medical liability awards.

"This issue became the central and deciding factor in a Supreme Court Justice election and it forced the Legislature to finally address the issue," said Mayor Brad Cole, of Carbondale at a news conference August 25 in Madison. His community lost both neurosurgeons who had served the southern third of the state when liability costs exploded there two years ago. Tragically, one of Cole's friends had to be airlifted to Missouri following a head injury because there wasn't a surgical specialist available locally anymore. She died from her injury.

www.keepdoctorsinwisconsin.org offers information about the exodus of physicians from other states without a cap, what voters can do to bring a cap back and the opportunity to become part of the campaign to keep doctors in Wisconsin. The site also contains a tremendous amount of other information, including the latest results from a statewide survey in mid-August of what likely Wisconsin voters think about the Supreme Court's ruling and an audio file of Mayor Cole from the news conference.

Until then, though, hospital administrator Sandy Anderson says she doesn't know what to say to prospective physicians she's trying to recruit for rural St. Clare Hospital in Baraboo. "I interviewed two orthopedic surgeons in the past two weeks to come to Baraboo and the first question that came out of their mouths was, 'What is Wisconsin doing about the new Supreme Court action?'"

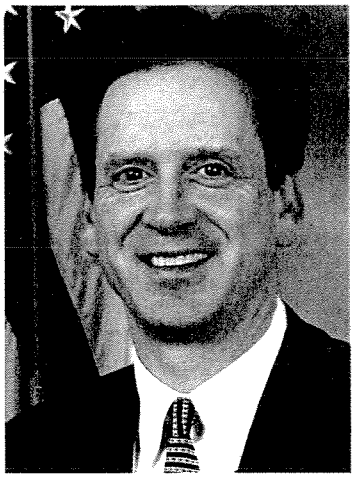
Anderson says she's short orthopedic surgeons now and hates to think what would happen if family doctors stopped delivering babies in her community. "In fact, in Baraboo, every single baby is delivered by a family practitioner and that's true for most rural hospitals," added Anderson.

If Oregon's experience is a guide, Wisconsin would be wise to address this problem sooner rather than later. Doctor Katherine Merrill predicts Wisconsin will see serious cracks in the health system in two to three years if the cap on jury awards isn't reestablished. She warns that once doctors stop practicing certain high-risk procedures, there's no turning back.

"The extra training involved to update and prove your skills is just beyond what most people are able and willing to do," explains Dr. Merrill. "Probably once people stop doing obstetrics they'll never do it again. You'll have to recruit new ones to do it."

Legislation as good as its advertising

By Congressman Mark Green



Congressman Mark Green

I admit it. I'm occasionally guilty of something we in public office are known to do: over-exaggerate the effects of legislation. Those of us in the political arena often use a bit of hyperbole when we are arguing about ideas. Suddenly, rather inconsequential proposals become either panaceas or catastrophes, depending on your point of view.

However, sometimes legislation is as good as advertised. Ten years ago, when I was in the State Assembly, I authored the law that, among other things, placed a cap on noneconomic damages in medical liability cases. I argued that caps were critically important for both the survival of the Injured Patients and Families Compensation Fund and access to quality health care.

Of course, there were lots of great reasons for our legislation–including curbing frivolous lawsuits by trial attorneys hoping to win the "lawsuit lottery." But there were two overriding arguments we used in advocating for the cap in 1995. First, that many doctors, especially some in high-risk specialties, would quit their practice or leave Wisconsin because of rapidly escalating malpractice insurance rates. Second, that our state's health care costs were being artificially increased through these high premiums and the other costs of "defensive medicine."

Let's see if our rhetoric back then matches today's reality.

Ten years ago, some doctors told me they'd soon have to retire or look elsewhere to practice medicine. Our rural areas, in particular, were in danger of losing important specialty practices—like obstetrics. Today's good news is that not only have the caps reversed the risk of doctors leaving the state, but they've actually become a recruiting tool for clinics and hospitals in trying to bring great physicians here to practice.

That means there are more doctors saving lives and helping people get well in Wisconsin. I've met doctors who told me they recently moved here almost entirely because of the efforts Wisconsin takes to control malpractice premiums. Ask their patients—better yet, ask their patients' families and friends—if these physicians' decision to move to Wisconsin has made a difference in their lives.

Back in 1995, we argued that health care costs were rapidly increasing not only because of rising malpractice premiums, but also because of the unnecessary tests and procedures that some felt driven to consider as part of "defensive medicine." Treatment decisions should obviously be solely based on sound medical judgment—not an effort to build a defense against potential malpractice claims.

Now, no one is going to argue that health care costs aren't still rising too high and too quickly, but can you imagine what those increases would be like if we return to the days of unlimited liability? Unfortunately, we may soon find out.

All in all, I couldn't have asked for a better result than what we've seen the past 10 years. The noneconomic damage cap has worked as well, if not better, than we promised back in 1995.

Sadly, all that we've accomplished with our legislation is in jeopardy because of the recent Supreme Court decision. As the original author of the medical malpractice cap, I am very proud our work has delivered such great results. I hope our leaders in Madison recognize the success these caps have had in our state and work quickly to reinstate a strong liability cap.

If we fail, we're likely to once again see doctors fleeing Wisconsin for states that value quality medical care more than trial lawyers' bank accounts.

Currently serving his third term in the US House of Representatives, Congressman Green represents Wisconsin's 8th Congressional District.

Giving booster seats a boost

"Recent research shows that motor vehicle crashes remain the leading cause of death and disability for children between the ages of 4 through 7 years," says Rep. Jerry Petrowski (R-Marathon), co-author of a bill that would create a booster seat requirement to cover older children.

Current law does not mandate booster seat use for children over 4 years of age or 40 pounds. Among other things, the bill (Assembly Bill 618/Senate Bill 305) would require that children aged 4 through 7 who weigh between 40 and 80 pounds and are under 4 feet 9 inches tall must be properly restrained in a child booster seat.

Passage of the bill will not only save lives, but could bring $2.5 million to Wisconsin in federal funds by bringing Wisconsin into full compliance with "Anton's Law." Our current child safety seat laws are inadequate, and parents look to the current inadequate law to keep their children safe. [The bill] will bring federal dollars to help parents purchase child safety seats as well as provide funds to educate parents of safety seats' importance," says Sen. Carol Roessler (R-Oshkosh), the Senate co-author.

The national Safe Kids campaign gave Wisconsin an "F" and ranked it 8th worst in the country for child occupant protection.

Drug repository program expands

"Nick's Law," proposed in honor of Kenosha cancer patient Nick Scavone, established Wisconsin's cancer drug repository in 2004. The cancer drug repository program allows individuals to donate unused prescription drugs or supplies used to treat cancer for redistribution to others, often those who can least afford them.

In summer 2005, a new law expanded the program to include prescription drugs and supplies for other chronic diseases. The bill, supported by the Wisconsin Medical Society, passed the legislature on unanimous votes and was signed into law by Governor Doyle.

The Wisconsin Department of Health and Family Services is currently drafting the rules for the program. Once the rules are complete, donations may be made at any medical facility or pharmacy that elects to participate in the program.

Restoring caps a Capitol priority

The Wisconsin State Legislature is not willing to let Wisconsin slip into a medical liability crisis and is working to pass a law that restores the caps on noneconomic damages in medical liability cases. The legislature "must act immediately to prevent potentially catastrophic consequences of the Supreme Court decision invalidating caps on noneconomic damages" said Rep. **Sheldon Wasserman, MD** (D-Milwaukee).

Senate Majority Leader Dale Schultz (R-Richland Center) called restoring the caps a "key issue" and Assembly Speaker John Gard (R-Peshtigo) created a Medical Malpractice Reform Task Force. Made up of five legislators (three Republicans, two Democrats) and five members of the public, the Task Force's mission is to craft a new law that would withstand any future constitutional challenge.

Even with considerable support, such legislation faces a long journey to pass both houses of the legislature and be signed by the Governor. The courts could also rule the new caps unconstitutional. If the issue is not addressed legislatively, there would be a push for an amendment to the Wisconsin Constitution. For that to happen, an identical amendment must be passed by two consecutive sessions of the legislature and then be approved by voters in a statewide referendum. Such an amendment does not require the Governor's approval and the courts cannot invalidate clauses of the constitution in the same way that they might overturn legislation.

For talking points, sample letters and other help in contacting your legislator about this issue, visit the "What Can I Do?" page at the Web site www.keepdoctorsinwisconsin.org.

Voters Agree

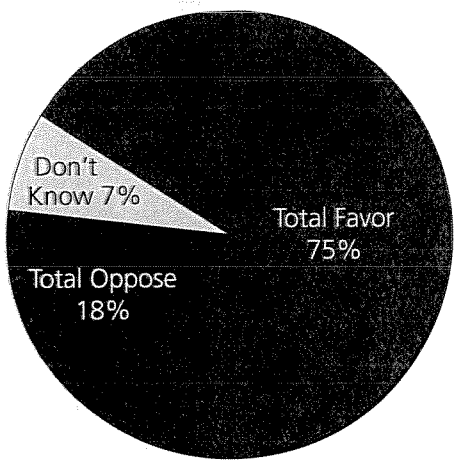
Survey reveals broad support for caps on noneconomic damages

Wisconsin voters support limits on intangible awards for damages like pain and suffering in medical liability cases, according to a statewide poll sponsored by the Wisconsin Medical Society (Society) and the Wisconsin Hospital Association.

When asked whether Wisconsin should cap noneconomic damages to prevent higher health costs associated with frivolous lawsuits and unnecessary medical testing, a clear majority agreed.

Public Opinion Strategies surveyed 500 likely Wisconsin voters in August. The poll found a majority want the cap on noneconomic damages reinstated, despite the Wisconsin Supreme Court's July ruling that the state's decade-old cap is unconstitutional.

"It's clear that voters understand the connection between unlimited awards and the consequence of higher health costs," said **Susan Turney, MD**, Society EVP/CEO.



When voters are educated about the issue, they overwhelmingly support caps on noneconomic damages in medical liability cases.

Voters across party lines are more likey to vote for state leaders who support a cap on noneconomic damages in medical liability cases.

Source: Wisconsin Medical Society/Wisconsin Hospital Association Medical Malpractice Survey, August 14-15, 2005

MEDICAL LIABILITY WORD SEARCH

A	F	F	O	R	D	A	B	L	E	C	J	S
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AFFORDABLE
CAPITOL
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CARE
COURT
DOCTOR
HEALTH
JURY
LAWSUIT
LIABILITY
MALPRACTICE
NONECONOMIC
OBSTETRIC
PATIENT
PRACTICE
PREMIUM
PROTECTION
RELOCATE
TORT
WISCONSIN

Statewide crisis leads to local action

By Brad Cole

Brad Cole, Mayor
Carbondale, Ill.

The medical liability problems in Illinois hit home last summer when a friend of mine sustained a brain injury from falling down the steps of her home. She suffered a traumatic injury that needed a neurosurgeon's immediate attention, but she had to be flown more than 100 miles away, out of state to St. Louis, before she could be treated. The unfortunate situation in Carbondale, Ill. was the departure of the region's only two practicing neurosurgeons. Who knows what could have happened to save her life if we had not been without those valuable medical specialists.

When they decided to close their doors and relocate to states with more favorable malpractice insurance rates, it left the lower third of Illinois without a neurosurgeon. We also began to see the same trend of doctors leaving town in other specialty care fields, such as obstetrics and gynecology.

Medical malpractice insurance reform isn't the typical city council agenda item for a small town in southern Illinois. More often, we are dealing with the standard issues of police and fire service, water and sewer lines and road projects. But just more than a year ago, out of near desperation from the lack of attention by the Illinois General Assembly, the Carbondale City Council took action.

Without any substantive remedy from the state, we adopted a local ordinance under our home rule authority to regulate medical malpractice suits. The City Council enacted caps on noneconomic damages that may be awarded to lawsuits for cases alleged to have occurred in Carbondale. Further, in an effort to end the court shopping that often takes a lawsuit away from its local origin to a friendlier jury pool, a venue restriction was instituted. This restriction still will allow due process and equal treatment under the law, but it will require that if the alleged incident happened in Carbondale, the malpractice suit has to be filed in this county.

Naysayers were quick to point out that these moves would surely be found unconstitutional by the Illinois Supreme Court, but with no other alternative and no leadership from the state office-holders we took the initiative, and—to date—our ordinance remains on the books, valid and unchallenged in court.

We realize that this didn't solve the problem by itself, but our local steps were the catalyst to get real attention to the issue and to start the momentum toward genuine reform of the problem on a broader scale. Directly because of our efforts, I think, and combining the hard work of our local health care system, we have now seen the new hire of a neurosurgeon in Carbondale, and the trend of doctors pulling-up roots has calmed.

Unfortunately, this came too late for several people in the area, including my friend, who needed medical attention but could not easily obtain it in times of an accident or other severe medical trauma. Hopefully, no one else will ever have to be in that same situation when a friend or family member needs care. And, hopefully again, maybe our action will be part of the long-term solution to the overall issue of medical malpractice insurance reform.

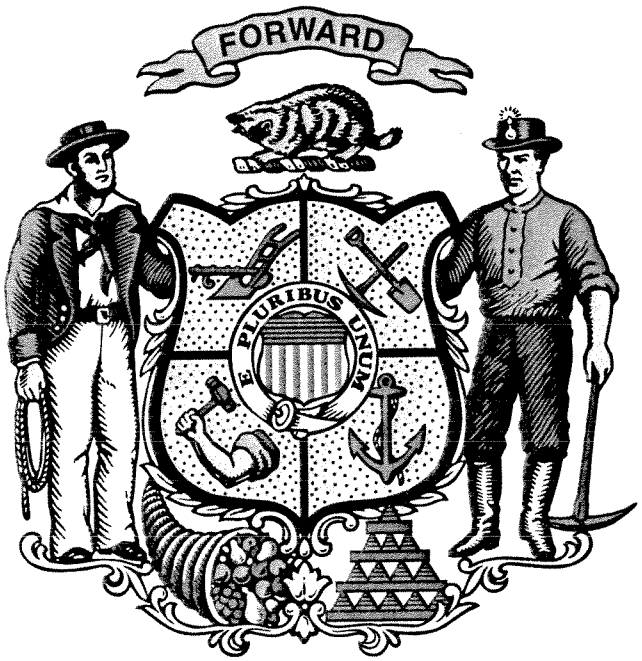
Note: The Illinois legislature passed a bill to create a cap on noneconomic damages, which Governor Rod Blagojevich signed into law August 25.

Keep Doctors in Wisconsin

A doctor where and when you need one. Whether a tragic accident or the birth of a baby, your concern shouldn't be how far it is to the specialist you need. But a recent State Supreme Court ruling means health care may get a lot more expensive for everyone in Wisconsin, and physicians may no longer be able to afford to practice here. Help ensure your family has access to care. Visit www.keepdoctorsinwisconsin.org.

WHA
WISCONSIN HOSPITAL ASSOCIATION

Wisconsin Medical Society
Your Doctor. Your Health.


FORWARD
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The Potential Impacts of Caps on Non-Economic Damages in Medical Malpractice Insurance in Wisconsin

September 2005

Pinnacle Actuarial Resources, Inc.
2817 Reed Road, Suite 2
Bloomington, Illinois 61704
(309) 665-5010

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EXHIBITS

The Potential Impacts of Caps on Non-Economic Damages in Medical Malpractice Insurance in Wisconsin

Executive Summary

For states struggling with medical malpractice insurance affordability and availability crises, the state of Wisconsin has long been viewed as a model state. This is due to the ability of the state's broad set of legislative reforms to provide stable and affordable premiums for healthcare providers and a stable environment for insurers. One of the foundational elements of Wisconsin's reforms, the cap on non-economic damages, was recently found to be unconstitutional. The Wisconsin Supreme Court in *Ferdon vs. Wisconsin Patients Compensation Fund* found that the cap violates the state's equal protection guarantees. The court also stated that the ruling does not impact the state's damage cap in wrongful death cases. This decision has led to questions regarding the impact the elimination of the caps may have on coverage availability, affordability and market stability.

Through a review of both publicly available and proprietary data sources, Pinnacle Actuarial Resources, Inc. (Pinnacle) has come to a number of key conclusions regarding the impact of the presence or absence of caps on non-economic damages on the Wisconsin medical malpractice liability environment. The highlights of our findings as regard the various issues include:

- While all caps on non-economic damages reduce losses, the impact diminishes as the size of the cap increases. A cap of $250,000 eliminates approximately 25% of unlimited losses, a $550,000 cap eliminates about 15% and a $1 million cap eliminates about 7%.

- States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have significantly better insurance company loss ratios and combined operating ratios.

- States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have more competitive

insurance markets as measured by the number of insurance companies providing coverage in the state.

- States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have medical malpractice insurance premiums that are much lower than the premiums in states that do not have effective caps.

- The Wisconsin medical malpractice insurance market has significantly outperformed most states in terms of both the affordability of medical malpractice rates and insurance company operating results.

In summary, states with damage caps are more attractive to both current and prospective insurers. This is due in part to the cap on one of the least predictable and most volatile elements of medical malpractice claim costs (i.e. the non-economic portion of high severity, permanent disability claims). This makes losses and therefore rates more predictable.

Similarly, states with damage caps are more attractive to current and prospective health care providers. This is because providers in states with effective caps:

1. have current rates lower than providers in states without effective caps,
2. have had more stable rate levels over the last several years, and
3. more insurance carriers competing for their business

This suggests that healthcare providers find medical malpractice insurance costs more affordable and coverage more available in states with effective caps.

Background

Pinnacle Actuarial Resources, Inc. (Pinnacle) has been retained by the Wisconsin Hospital Association (WHA) and the Wisconsin Medical Society (WMS) to perform analyses of the impact of the presence or absence of caps on non-economic damages at various levels. Specifically, they would like assistance evaluating the impact of:

1. Caps on non-economic damages on claims data from states without caps, and
2. Experience of other states based on the type of cap applicable in the state.

Pinnacle is an Illinois corporation that has been in property and casualty actuarial consulting since 1984. Our 14 consultants make Pinnacle one of the 10 largest property/casualty actuarial consulting firms in the U.S. We specialize in insurance pricing, loss reserving, alternative markets, legislative costing and market analysis and financial risk modeling. Our headquarters are located in Bloomington, IL.

Pinnacle has established a reputation as a provider of unbiased, independent, actuarially sound analyses and reports. This reputation is demonstrated in the variety of clients that have engaged us for projects similar to this one. Clients that have engaged Pinnacle in legislative costing and market evaluation assignments have included insurance industry associations (e.g. NAII, AIA), insurance departments and governmental panels (e.g. Connecticut, Maine, Ohio, Oregon), government insurance programs, (e.g. Virginia), trade associations (e.g. Oregon Medical Association, Illinois Hospital Association) and insurance companies. Pinnacle may be unique in the breadth of parties involved in the medical malpractice insurance system that have engaged us. A list of relevant research and client-related publications follows.

Relevant Pinnacle Reports and Research

- "A Report on Factors Impacting Medical Malpractice Insurance Availability and Affordability", Oregon Professional Panel for Analysis of Medical Professional Liability Insurance, October 2004
  (www.pinnacleactuaries.com/pages/publications/files/saiffinalreport.pdf)

- "Final Report on the Feasibility of an Ohio Patients Compensation Fund", Ohio Department of Insurance, May 2003 (www.ohioinsurance.gov/Legal/REPORTS/FinalReportOhioPatientComp.pdf)
- "Preliminary Report on the Feasibility of an Ohio Patients Compensation Fund", Ohio Department of Insurance, February 2003 (www.ohioinsurance.gov/Legal/Reports/Prelim_Patient_Compensation_Report_03-03-03.pdf)
- "The Case of the Medical Malpractice Crisis: A Classic Who Dunnit", Casualty Actuarial Society Discussion Paper Program, Spring 2004 (http://casact.org/pubs/dpp/dpp04/04dpp393.pdf)
- "The Impact of Medical Malpractice Litigation On the Health Care Consumer", A Report to The PLUS Foundation, Summer 2004

Data Sources

A number of data sources were used in the development of this analysis. The data sources relied upon included the following categories:

1. Oregon, Maine, and Florida Closed Claims Database
2. Medical Malpractice Rates and Rate Filings
3. Insurance Company Financial Statements
4. State Statutory and Regulatory Provisions for Medical Malpractice

A brief description of the data sources utilized in each area along with a description of the key data elements and potential limitations of the data follows for each category.

Closed Claims Databases

Statewide closed claim databases are valuable resources for the development of legislative costing estimates in medical malpractice. For this analysis, Pinnacle has relied on databases from the states of Oregon, Maine, and Florida. These databases were selected because the data was readily available, easily accessible and robust in the sense that several years of data for the vast majority of a state's medical malpractice claims experience was available. The use of these databases has enabled us to develop a range of estimated impacts of caps on non-economic damages at various levels which reflect some differing judicial systems and at the same time demonstrate a significant consistency in the estimated reductions in expected losses created by the caps.

In a previous study on behalf of the Oregon Professional Panel for Analysis of Medical Professional Liability Insurance, Pinnacle worked with a number of medical malpractice insurance companies in the state and the Oregon Medical Association to develop an independent, Oregon medical malpractice closed claims database. With these parties' permission Pinnacle has used this database to evaluate the impact of several of the proposed legislative changes. For more information on the specifics of this database, please refer to Pinnacle's earlier report for the Oregon Professional Panel. (www.pinnacleactuaries.com/pages/publications/files/saiffinalreport.pdf)

As a result of the 1977 Maine Health Security Act, "Every insurer providing professional liability insurance in this State to a person licensed by the Board of Licensure in Medicine or the Board of Osteopathic Licensure or to any health care provider shall make a periodic report of claims made under the insurance to the department or board that regulates the insured." This data has been compiled and provided in an electronic format for Pinnacle's analysis by the Maine Bureau of Insurance. For more information on the specifics of this database, please refer to Pinnacle's earlier report for the Maine Bureau of Insurance.

The Florida Department of Insurance has been collecting data on individual medical malpractice claims since 1975. This data contains tremendous descriptive detail about the claim damage amounts, but also about the characteristics of the claim itself. We have chosen to examine claims in the state of Florida that closed during the period from January 1, 1993 through March 1, 2003. This produced 21,639 individual claim records. For more information on the specifics of this database, please refer to Pinnacle's earlier report for the Ohio Department of Insurance.

In all three cases, losses were trended at an annual rate of 7%. The trend factor was selected after a review of recent rate filings from a variety of leading insurers in a variety of jurisdictions, including Wisconsin. In many cases, medical malpractice closed claim data does not contain a split between economic and non-economic damages. We reviewed the closed claim information that is publicly available from the Texas Department of Insurance which does contain the split between economic and non-economic. Based on this data approximately 65% of the total claim amount is due to non-economic damages for claims that closed for amounts between $250,000 and $2 million. For claims greater than $2 million the portion of the claim representing non-economic damages was 50%. Additional data sources such as the Florida Closed Claim database and other industry studies indicate that non-economic damages range from 50% to nearly 70% of the total claim amounts. Unless specific claims detail was available, we have assumed that 60% of claims values, excluding allocated loss adjustment expenses are non-economic damages.

The American Academy of Actuaries has provided guidance on the limitations of using closed claims databases. This guidance can be found at www.actuary.org/pdf/casualty/medmal_042005.pdf. Readers of this report are advised to be aware of these limitations. In spite of these cautions,

closed claim databases such as those used in this analysis remain the most readily available source of large volumes of medical malpractice claims applicable for evaluating the impact of caps on non-economic damages and other legislative changes and are widely used and accepted. These data sources represent states with a variety of different approaches to medical malpractice liability law. While none of the states have a current medical malpractice environment perfectly identical to the climate that exists in Wisconsin subsequent to the *Ferdon* decision, the consistency of the analysis results between the various states suggests that closed claim data are valid for the purpose of estimating the impact of non-economic damage caps. One example of the differences between the states is Maine's mandatory medical review panels. Another is Florida's judicial system which has created a very difficult climate for medical malpractice liability claims that has resulted in a large number of high severity claims. Overall, it appears that the information available in Oregon is most suited to estimating the impact of caps on non-economic damages in Wisconsin. The Florida data may slightly overstate the impact of the damage caps due to the greater frequency and severity of large losses.

Coincidentally, Oregon is another state that has experienced a Supreme Court ruling finding that non-economic damage caps are unconstitutional. The significant rate increases, reduced coverage availability, deteriorating industry operating results and reduced competition in Oregon are troubling evidence of the impact removing damage caps can have on a stable medical malpractice insurance market.

Medical Malpractice Rates and Rate Filings

A tremendous resource for historical rate levels of key insurers in all states is the Medical Liability Monitor. This publication conducts an annual survey of the leading medical malpractice insurers in all 50 states. The information that is requested is mature claims-made rates with limits of $1 million/$3 million (occurrence/aggregate). The Medical Liability Monitor provides rate level information by state for three large physician specialties (internists, general surgeons, and OB/GYNs). Typically data from several insurers is available in a given state. This information is a widely recognized and accepted resource.

Pinnacle has performed an internal analysis of the last nine years of Medical Liability Monitor

data to create an assessment of current insurance industry rate levels by specialty and state as well as average annual rate changes over the period. We attempted to track the rate changes of the largest insurer in state that provided data to the Medical Liability Monitor over the entire nine year period as a measure of rate level changes over the period. Generally, this was the largest or second largest insurer by market share. In a few states, data for a single insurer was not available for the entire period and a judgmental adjustment to reflect the change in leading carriers was necessary. In states where the limits were not typically provided due to coverage from a patient compensation fund or other factors, an estimated adjustment to get the rates to a more "apples to apples" basis was made using available PCF rates and other information. This was used to evaluate the current affordability of medical malpractice coverage by state.

A couple of caveats about this approach to industry rate levels are necessary. First, the current rates for one leading writer of medical malpractice for three specialties in each state are not a precise measure of overall rate levels for the entire industry. Medical malpractice insurers do not move in concert with one another and a leading insurer may have rates that differ materially from other insurers in the state. However, the rate levels of one of the two largest insurers in the state does serve as a reasonable proxy for industry rate levels which are impractical to measure. One complicating factor in this assessment is that other rating factors, including limits purchased and self-insured retentions selected, movement from traditional insurance to self-insurance, and the impact of claims-free credits and experience rating changes are not measured in manual rate changes. Still, the most significant factor influencing health care provider premiums are manual rate level changes.

Insurance Company Financial Statements

In evaluating the relative profitability of both individual medical malpractice insurers and the medical malpractice insurance industry in various states, Pinnacle relied heavily on insurance company annual financial statement data compiled by the A.M. Best Company. Pinnacle examined premiums, losses, loss adjustment expenses and underwriting expenses by line and state. This information was aggregated across all insurers to produce industry composites.

One of the complications of using this data source is that it is limited to carriers that have an

A.M. Best rating. Several writers of medical malpractice insurance, including leading writers such as Northwest Physicians Mutual Insurance Company in Oregon, are no longer in the annual statement databases. For some significant insurers, Pinnacle added data directly from company annual statements to the A.M Best data to produce more accurate industry composite results.

State Statutory and Regulatory Provisions for Medical Malpractice

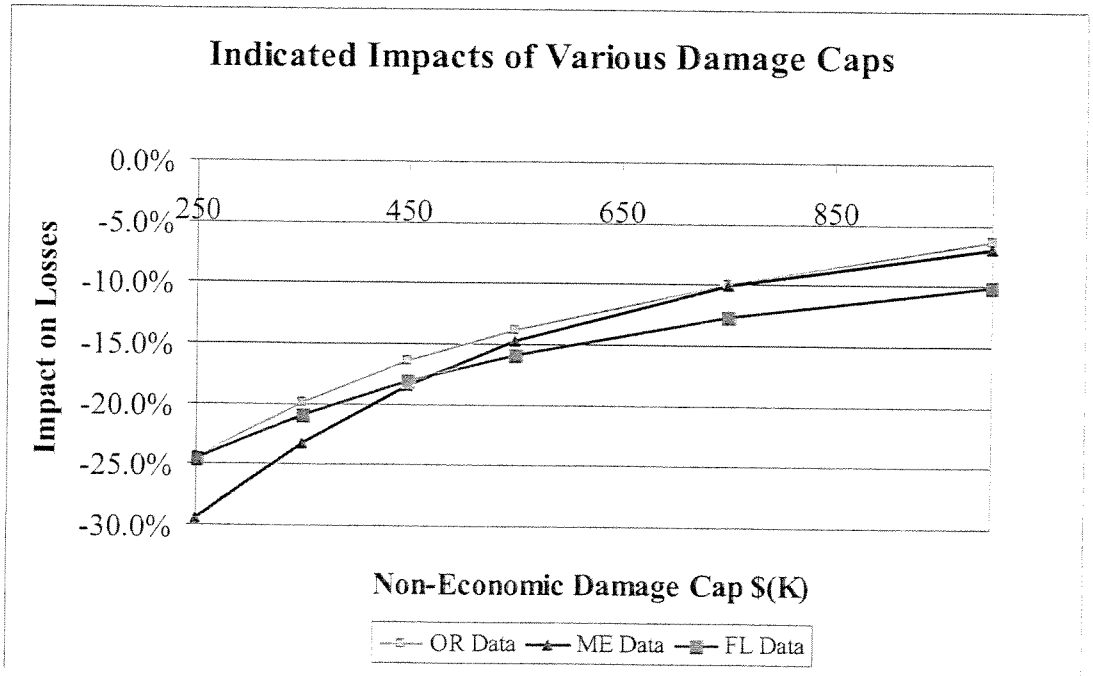
A thorough understanding of the current statutory caps on non-economic damages and any significant changes in these caps over the last decade by state was viewed as essential to providing a meaningful summary of both the presence or absence of damages caps in other states and also the impact these caps have had on the availability and affordability of premiums and insurer loss ratios and combined operating ratios. States with both non-economic damage caps and total caps, e.g. Colorado, were assigned to the state to which their non-economic cap belongs. States with only total damage caps, e.g. Indiana, were given judgmental assignments to the group that their caps most appropriately matched. Reassigning or removing the states with total caps did not materially impact the overall findings of the analysis.

We relied primarily on two resources in compiling information on applicable caps in each state over the last decade. One resource is the website of the law firm of McCullough, Campbell & Lane (www.mcandl.com) which provides a concise summary of many medical malpractice statutory features by state along with the relevant legal citations. The other resource is the website of the American Tort Reform Association (ATRA) which provides a detailed summary of Civil Justice Reforms by State. This information includes both currently active legislation and historical changes. We have followed categorizations of states by non-economic damage caps as Low ($250,000), Medium (between $250,000 and $550,000) and High (greater than $550,000) as they appear to provide reasonable groupings of states with comparable industry conditions. These groupings were recently published in an article in the September 2005 Best Review entitled, "Doctors' Orders", which utilized ATRA data. Pinnacle has used information from both of these resources as a reference in several previous projects and found them to be reliable and accurate.

Discussion and Analysis

While all caps on non-economic damages reduce losses, the impact diminishes as the size of the cap increases. A cap of $250,000 eliminates approximately 25% of unlimited losses, a $550,000 cap eliminates about 15% and a $1 million cap eliminates about 7%. In order to estimate the impact of a cap on non-economic damages, Pinnacle's analysis started by trending the closed claims in the Oregon, Maine and Florida closed claims data set by an annual rate of 7% for indemnity payments and ALAE payments. As noted above, the trend factor was selected based on a review of recent rate filings from leading insurers in a variety of jurisdictions, including Wisconsin. Losses were trended assuming that the non-economic damage caps would begin to apply on January 1, 2006. Exhibit 1 summarizes the results of this analysis.

The results of applying non-economic damage caps ranging from $250,000 to $1,000,000 are remarkably similar for all three databases. A cap on non-economic damages of $250,000 results in an estimated reduction in losses and allocated loss adjustment expenses (ALAE) of between 24.5% and 29.5%. This steadily decreases as the cap increases until the $1 million cap only eliminates 6.3% to 10.1% of total loss and ALAE. We also believe the results in Florida may overstate the likely impact of this high of a cap in Wisconsin due to significant differences in the judicial systems in the two states. The results of this analysis are shown graphically below.



The reverse of this finding is also true. That is we expect that the removal of the Wisconsin caps on non-economic damages which were at approximately $450,000 are likely to increase expected losses by between 18% and 22%. Because of the role played by the Wisconsin Injured Patients and Families Compensation Fund (IPFCF) as the excess coverage provider in the state we expect it will bear a significant portion of the increase losses created by the elimination of the caps. Our analysis suggests that insurance company rates will need to increase by between 12% and 15% while IPFCF assessments may need to more than double. Note that this will reduce the impact on primary insurance company rates but not on health care provider costs as they are responsible for IPFCF assessments as well as their insurance premiums.

This increase in medical malpractice insurance costs will likely involve a single rate correction or potentially a single rate change followed by additional adjustments as the impact is better understood and more data is collected. However, the potential for increased variability in insurance company loss results and increases in loss severity inflationary trends also present the risk of additional rate increases and deterioration of industry loss results. This behavior has been manifested in a number of states without effective caps on non-economic damages and will be discussed later in the report.

The extent to which these estimated cost reductions will be realized depends on a number of issues. The cost reductions do not reflect the potential impact of judicial challenges of damage caps which could delay or reduce the realization of the potential savings. In addition, there is a potential for the migration of some non-economic damages to economic damages. For example, damages paid to the family of a deceased mother who had no outside income can be broadly awarded as pain and suffering, or non-economic damages. If caps are put in place, the costs of the services that can be replaced may be more fully itemized and listed as economic damages. Furthermore, there is no consideration in this analysis of indirect effects such as reductions in claim frequencies due to the cap or reductions in ALAE due to reduced settlement delays created by the caps. These indirect effects are quite difficult to quantify and generally would lead to our estimates being somewhat conservative, i.e. potentially understating the impact of the caps.

This inability to quantify indirect effects of non-economic damage caps based on closed claims data suggests that an additional approach is also needed. Therefore, Pinnacle has compiled industry rate, premium and loss data by state so that state experience by different categories of damage caps can be compared.

States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have significantly better insurance company loss ratios and combined operating ratios. Exhibits 2 through 4 summarize three important measures of the health of an insurance market: loss and defense and cost containment expense (DCC) ratios, combined ratios and market concentrations by the type of damage cap that exists in a state. Loss and DCC ratios are the ratio of losses and defense and cost containment expenses as a percentage of premium earned. The combined ratio starts with the loss and DCC ratio and adds ratios of both other loss adjustment expenses and underwriting expenses to premium. When these ratios are above 100% an insurance company or state insurance market is paying out more than they are collecting in premiums and can signal a need for rate increases or the potential for reduced access to coverage. Note that this metric does not reflect the investment income that insurers can earn between the time premiums are collected and losses and other expenses are paid.

As shown on Exhibit 2, Wisconsin's five year loss and DCC ratio is lower than even the average for states with low noon-economic damage caps. In fact, it is one of the lowest of any state. The statewide combined ratio is also one of the lowest in the nation. As you can see in Exhibits 2 and 3, the states with low or medium caps demonstrate loss and DCC ratios and combined ratios that are much lower than states with high caps or no caps. The five year average combined ratios of over 135% shown by the states without effective caps have led to voluntary company exits from the marketplace, company liquidations and dramatic rate increases by insurers remaining in these states.

States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have more competitive insurance markets as measured by the number of insurance companies providing coverage

in the state. An important measure of the availability of insurance coverage is the degree of competition between insurers to provide coverage in a state. One way to measure the degree of competition is the level of market concentration. A more competitive market will tend to be less concentrated. We have examined medical malpractice market concentrations over time and by state. This type of analysis is widely used in insurance and many other markets to measure the competitiveness of a market.

The metric we used to measure market concentration is the Herfindahl-Hirschman Index (HHI). HHI is computed as the sum of the squares of the market shares of the firms competing in a market. The HHI can range from a minimum of close to 0 to a maximum of 10,000. The U.S. Department of Justice considers a result of less than 1,000 to be a competitive marketplace, a result of 1,000 - 1,800 to be a moderately concentrated marketplace, and a result of 1,800 or greater to be a highly concentrated marketplace. In insurance, it is common to sum the data for statutory insurance companies that operate within a single group in terms of their ownership structure and pooling of financial results. Exhibit 4 shows the HHI results by the state categories by damage cap type for 2004 and a five year average (2000-2004) for the medical malpractice market in total.

Wisconsin's marketplace, which ranked 27th in total premium volume, is slightly less concentrated (HHI=1,656) than most states. Generally, states with caps are much more competitive as reflected in significantly lower HHI statistics. The high average HHI for states with medium caps is heavily influenced by a few states with dominant domestic mutual insurers founded by state physicians groups.

States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have medical malpractice insurance premiums that are much lower than the premiums in states that do not have effective caps. It is noteworthy that not only are loss ratios lower in states with effective damage caps ($250K to $550K), signifying better insurance company results and thus the potential for a more competitive market and greater availability of coverage; but, these states also have significantly lower premiums on average suggesting more affordable coverage. The

results of this rate comparison are summarized in Exhibits 5 through 7. States with small ($250K) and medium caps on non-economic damages have average rates of $11,600 to $13,800 for the internal medicine specialty while state with no caps or caps that were found to be unconstitutional have average rates in excess of $18,000. Similar differences of 25% to 35% exist for the General Surgery and OB/GYN specialties. This results in average OB/GYN rates in states with effective caps being over $25,000 lower than rates in states without caps. Wisconsin rates are among the lowest in the nation in all three specialties.

Similarly, average rate levels over the last six years in states with effective caps have increased between 8% and 12% while rates in states without caps have increased between 14% and 19% annually. This means that for states without caps, many medical malpractice premiums have more than doubled in six years. Wisconsin annual rate increases over the period have been less than 5%.

The Wisconsin medical malpractice insurance market has significantly outperformed most states in terms of both the affordability of medical malpractice rates and insurance company operating results. Exhibits 2 through 7 show that the state of Wisconsin has significantly outperformed most states in all of the categories presented. Market concentration is lower than average suggesting better than average insurer competition. Industry loss and ALAE ratios and combined operating ratios are much lower than national averages. Leading company rate levels and average annual rate changes over the last six years have typically been among the ten best states in the country. These metrics suggest that the state of Wisconsin's broad approach to medical malpractice reform which includes the IPFCF, caps on attorney contingency fees, recognition of collateral sources, mandatory periodic payments, and damage caps, have led to a market with better than average availability and affordability of coverage for health care providers and an environment that encourages competition for insurers while still offering an opportunity to generate reasonable operating results in a stable loss environment.

It appears based on both the expected impact of the removal of the state of Wisconsin's previous non-economic damage cap and the current conditions in other states that Wisconsin's balanced environment is now in jeopardy without meaningful caps. It appears that either a low cap such

as California's $250,000 cap or a medium cap of less that $550,000 are essential to maintaining the current availability, affordability and stability of medical malpractice coverage in the state of Wisconsin.

Disclosures

Distribution and Use

This report is being provided for the use of the Wisconsin Hospital Association and the Wisconsin Medical Society who commissioned the study. It is understood that this report may also be distributed to makers of public policy and various stakeholders in the healthcare industry in the State of Wisconsin. Distribution to these parties is granted on the conditions that the entire report be distributed rather than any excerpts and that all recipients are made aware that Pinnacle is available to answer any questions regarding the report.

These third parties should recognize that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data, computations, interpretations contained herein that would result in the creation of any duty or liability by Pinnacle to the third party.

Reliances and Limitations

Judgments as to conclusions, recommendations, methods, and data contained in this report should be made only after studying the report in its entirety. Furthermore, Pinnacle is available to explain any matter presented herein, and it is assumed that the user of this report will seek such explanation as to any matter in question. It should be understood that the exhibits, graphs and figures are integral elements of the report.

We have relied upon a great deal of publicly available data and information, without audit or verification. Pinnacle reviewed as many elements of this data and information as practical for reasonableness and consistency with our knowledge of the insurance industry. As regards the legislative costing elements of this report, it is possible that the historical data used to make our estimates may not be predictive of future experience in Wisconsin. We have not anticipated any extraordinary changes to the legal, social or economic environment which might affect the size or frequency of medical malpractice claims beyond those contemplated in the proposed legislative changes.

Loss and loss adjustment expense estimates are subject to potential errors of estimation due to the fact that the ultimate liability for claims is subject to the outcome of events yet to occur, e.g., jury decisions, judicial interpretations of statutory changes and attitudes of claimants with respect to settlements. Pinnacle has employed techniques and assumptions that we believe are appropriate, and we believe the conclusions presented herein are reasonable, given the information currently available. It should be recognized that future losses will likely deviate, perhaps substantially, from our estimates.

Pinnacle is not qualified to provide formal legal interpretations of state legislation. The elements of this report that require legal interpretation should be recognized as reasonable interpretations of the available statutes, regulations, and administrative rules. State governments and courts are also constantly in the process of changing and reinterpreting these statutes.

Exhibits

Wisconsin Hospital Association/Wisconsin Medical Society
Impact of Various Caps on Non-Economic Damages

Exhibit 1

I. Indicated Impact Based On Oregon Closed Claim data

Trended Size of Loss	Trended Loss & ALAE Uncapped	Indicated Reduction in Overall Loss and ALAE					
		$250K Cap	$350K Cap	$450K Cap	$550K Cap	$750K Cap	$1M Cap
0-25	15,882,386	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-50	16,393,941	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
50-100	26,406,073	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
100-150	19,480,715	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
150-200	19,237,755	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
200-250	14,575,199	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
250-350	27,434,350	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
350-500	38,874,756	-2.2%	0.0%	0.0%	0.0%	0.0%	0.0%
500-1000	101,772,269	-22.8%	-10.0%	-2.5%	-0.3%	0.0%	0.0%
1m-2m	123,309,631	-42.2%	-35.4%	-28.6%	-21.8%	-10.3%	-1.9%
2m+	177,954,398	-37.3%	-34.9%	-32.4%	-30.0%	-25.2%	-19.2%
Overall	581,321,472	-24.5%	-19.9%	-16.4%	-13.9%	-9.9%	-6.3%

II. Indicated Impact Based On Maine Closed Claim data

Trended Size of Loss	Trended Loss & ALAE Uncapped	Indicated Reduction in Overall Loss and ALAE					
		$250K Cap	$350K Cap	$450K Cap	$550K Cap	$750K Cap	$1M Cap
Overall	199,784,402	-29.5%	-23.3%	-18.6%	-14.8%	-10.1%	-7.0%

III. Indicated Impact Based On Florida Closed Claim data

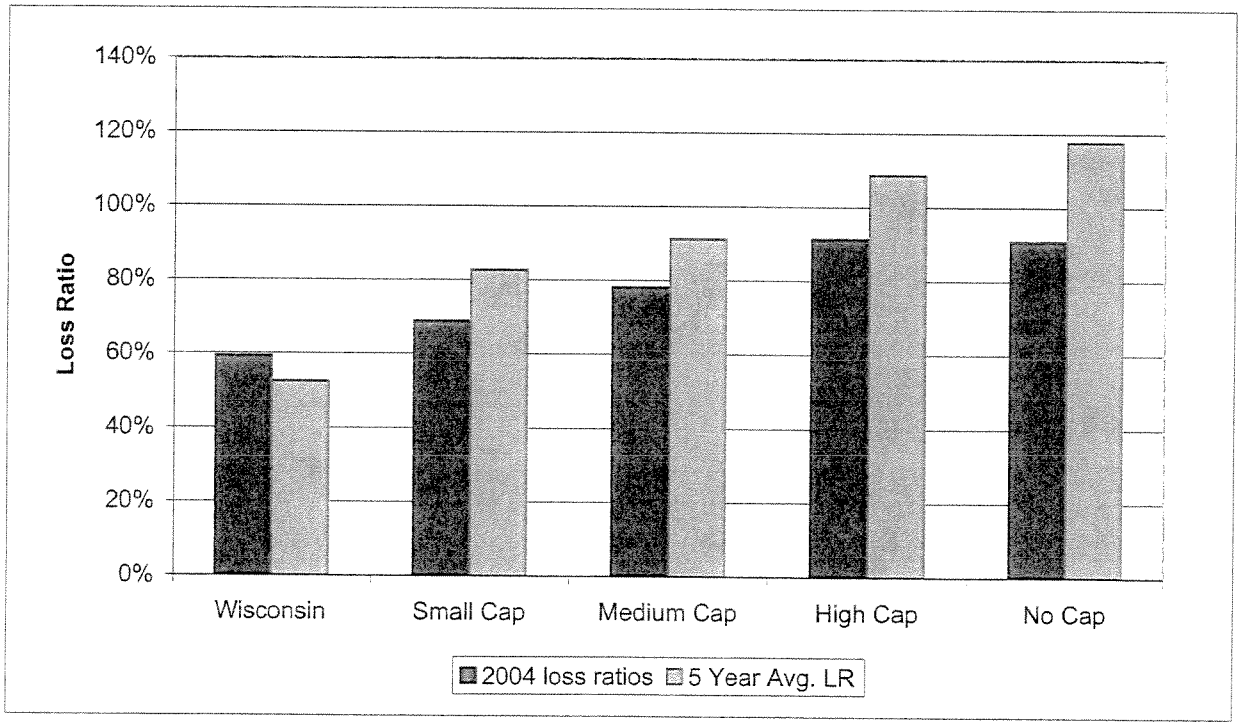
Trended Size of Loss	Trended Loss & ALAE Uncapped	Indicated Reduction in Overall Loss and ALAE					
		$250K Cap	$350K Cap	$450K Cap	$550K Cap	$750K Cap	$1M Cap
Overall	11,219,742,990	-24.6%	-21.0%	-18.1%	-15.8%	-12.7%	-10.1%

Assumes Medical Malpractice Loss Inflation of 7.0% for Indemnity and ALAE.

Wisconsin Hospital Association/Wisconsin Medical Society
Loss Ratios

Industry Experience by State Predominant Damage Cap

Category	2004 Loss Ratio	5 Yr. Average Loss Ratio
Wisconsin	**59.32%**	**52.53%**
Small Cap	68.91%	82.75%
Medium Cap	78.14%	91.32%
High Cap	91.50%	108.69%
No Cap	90.94%	117.72%
Premium Weighted Average	87.40%	110.82%



Source: AM Bests' Aggregates and Averages

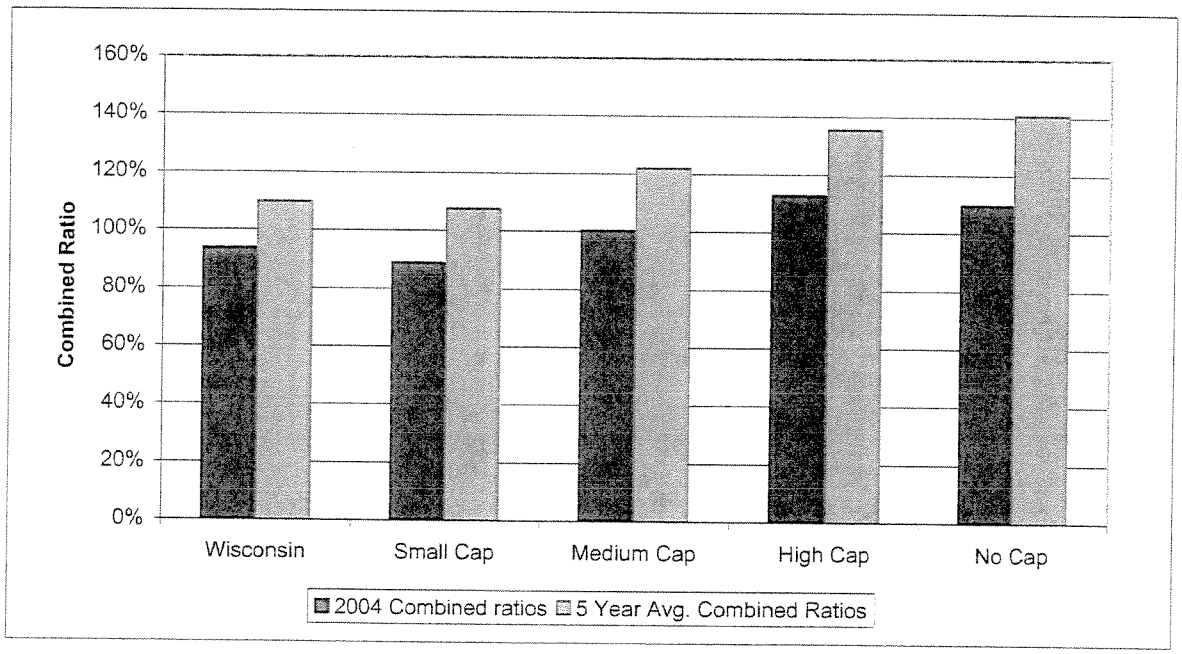
Predominant State Groups are:

Small Cap -	CA,CO, KS, MT, UT
Medium Cap -	AK, HI, ID, IN, MA, MI, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society
Combined Ratios

Industry Experience by State Predominant Damage Cap

Category	2004 Comb. Ratio	5 Yr. Average Comb. Ratio
Wisconsin	**93.89%**	**109.86%**
Small Cap	88.92%	107.65%
Medium Cap	100.34%	121.93%
High Cap	112.89%	135.64%
No Cap	109.84%	140.77%
Premium Weighted Average	106.90%	135.04%



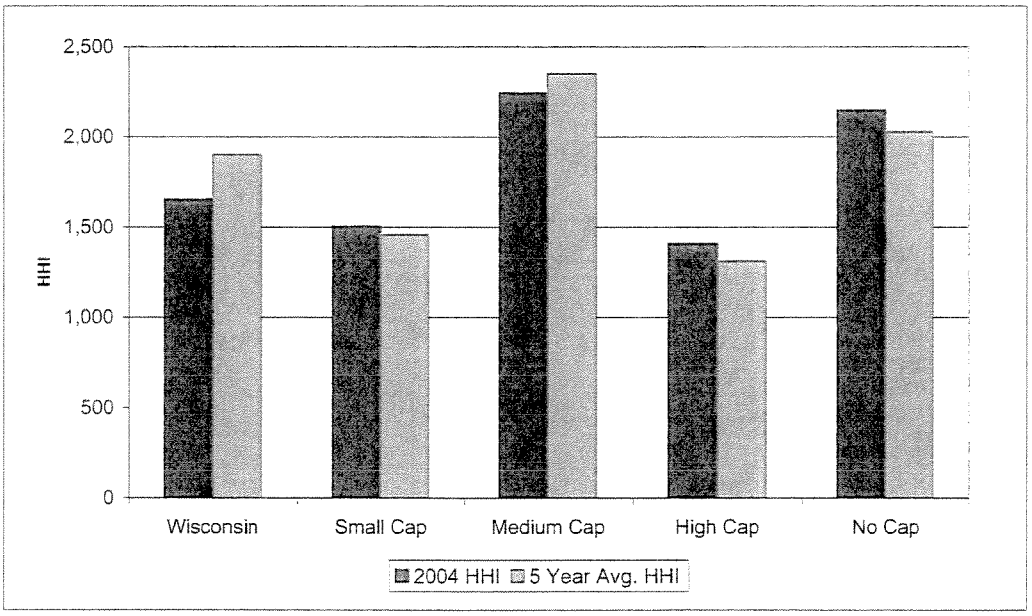
Source: AM Bests' Aggregates and Averages

Small Cap -	CA,CO, KS, MT, UT
Medium Cap -	AK, HI, ID, IN, MA, MI, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society Market Concentration by State by Year

Comparison by Damage Cap

Category	2004 HHI	5 Year Avg. HHI
Wisconsin	**1,656**	**1,904**
Small Cap	1,507	1,459
Medium Cap	2,246	2,353
High Cap	1,409	1,312
No Cap	2,150	2,028
Written Premium Weighted Average	2,033	1,941



Data Sources: 2004 Direct Written Premium: A.M. Best Page 15 data.

Comments: HHI (Herfindahl-Hirschman Index) is calculated by squaring the market share of each firm competing in a market, and then summing the resulting numbers. The index can range from 0 to 10,000. The U.S. Department of Justice considers a result of less than 1,000 to be a competitive marketplace, a result of 1,000-1,800 to be a moderately concentrated marketplace and a result of 1,800 or greater to be a highly concentrated marketplace.

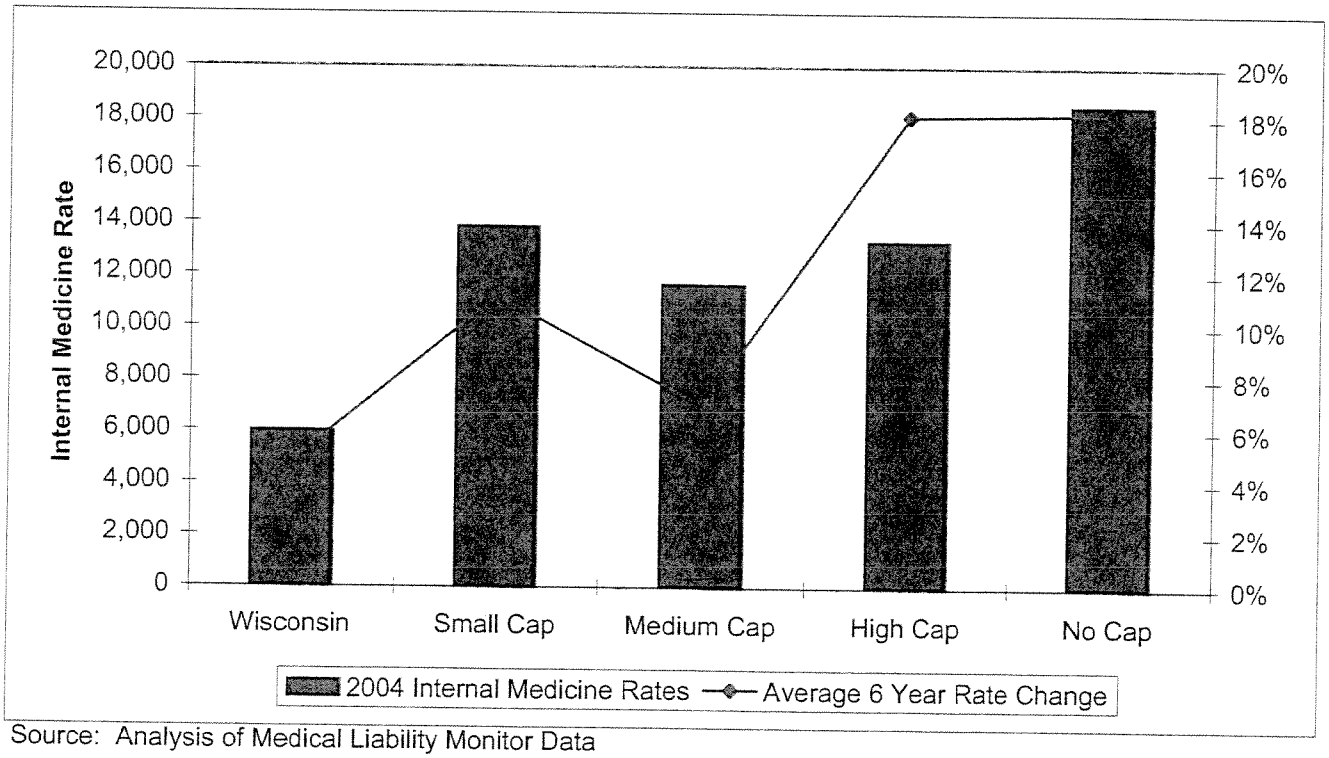
Predominant State Groups are:

Small Cap -	CA,CO, KS, MT, UT
Medium Cap -	AK, HI, ID, IN, MA, MI, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society
Internal Medicine Rates and Rate Levels

Comparison by Damage Cap

Category	2004 Rate	Average 6 year Rate Change
Wisconsin	**5,973**	**4.85%**
Small Cap	13,834	11.17%
Medium Cap	11,615	6.98%
High Cap	13,292	18.11%
No Cap	18,514	18.24%
Physician Weighted Average	16,587	15.78%



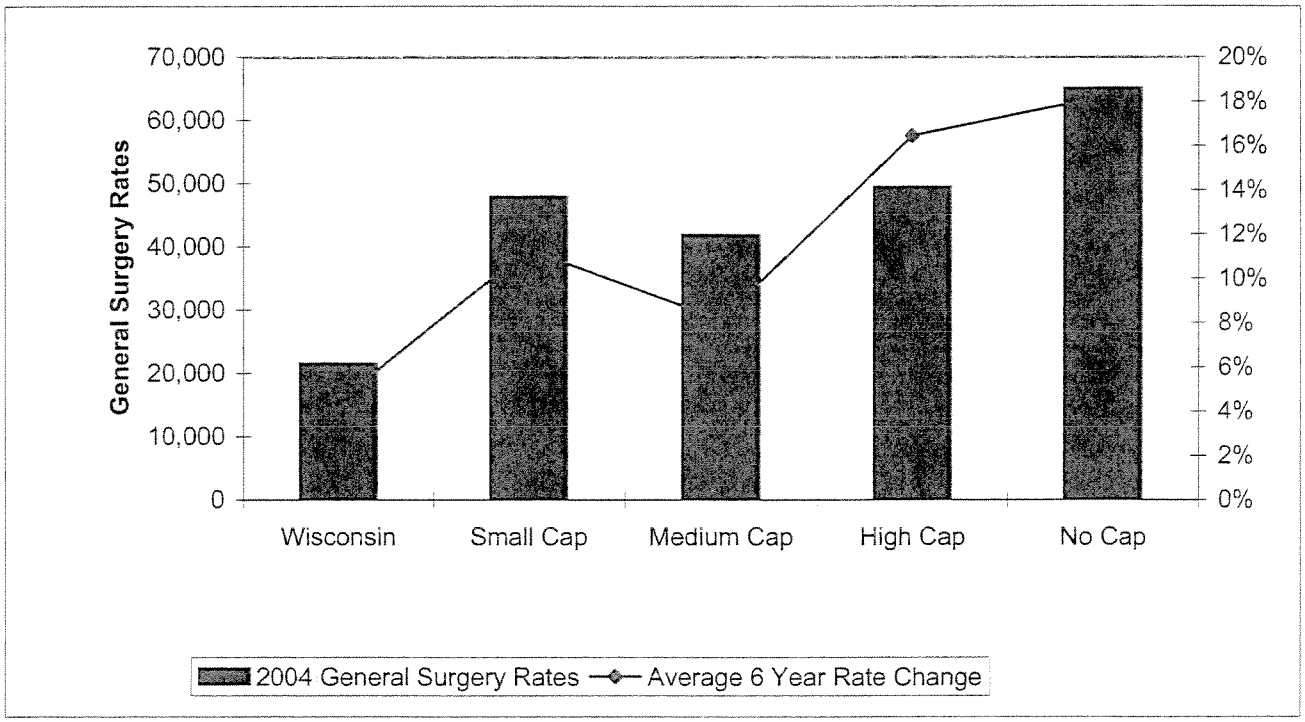
Source: Analysis of Medical Liability Monitor Data

Small Cap -	CA, ID, KS, MT, UT
Medium Cap -	AK, CO, HI, IN, LA, MA, MI, MS, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society
General Surgery Rates and Rate Levels

Comparison by Damage Cap

Category	2004 Rate	Average 6 year Rate Change
Wisconsin	**21,504**	**4.44%**
Small Cap	47,862	11.33%
Medium Cap	41,819	8.13%
High Cap	49,446	16.45%
No Cap	64,974	18.21%
Physician Weighted Average	58,470	15.81%



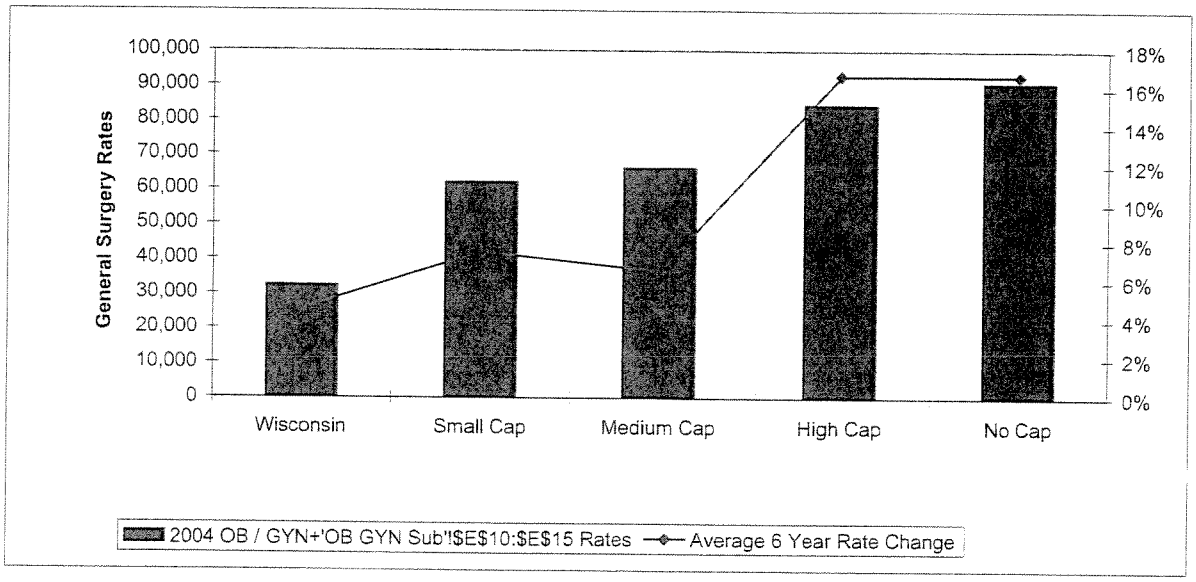
Source: Analysis of Medical Liability Monitor Data

Small Cap -	CA, ID, KS, MT, UT
Medium Cap -	AK, CO, HI, IN, LA, MA, MI, MS, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society
OB / GYN Rates and Rate Levels

Comparison by Damage Cap

Category	2004 Rate	Average 6 year Rate Change
Wisconsin	**32,255**	**4.61%**
Small Cap	61,999	7.58%
Medium Cap	66,241	6.59%
High Cap	84,354	16.72%
No Cap	90,753	16.72%
Physician Weighted Average	83,223	14.15%



Source: Analysis of Medical Liability Monitor Data

Small Cap - CA, ID, KS, MT, UT
Medium Cap - AK, CO, HI, IN, LA, MA, MI, MS, ND, OK, SD, WI
High Cap - MD, MO, NM, VA
No Cap - AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY